



**RURAL HEALTH, Inc.**  
*We specialize in you*

**PATIENT REGISTRATION FORM**

Please provide a Driver's License **or** Picture Identification card, along with current insurance cards and any copay due at time of service

**Interpreter Status** Do you require an interpreter? [ ] Yes [ ] No

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

First name used: \_\_\_\_\_ Middle name, suffix \_\_\_\_\_

Previous Name (last, first): \_\_\_\_\_

Legal Sex: ( ) Male ( ) Female Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number: \_\_\_\_\_ Mother's maiden name: \_\_\_\_\_

Patient Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

Access to Patient Portal: [ ] Yes [ ] No

Patient Phone: Cell ( ) \_\_\_\_\_ - \_\_\_\_\_

- Consent to call - cell [ ] Yes [ ] No Consent to text [ ] Yes [ ] No

Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ - \_\_\_\_\_

Contact preference: [ ] Home [ ] Cell [ ] Work [ ] Mail [ ] Portal

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Pharmacy Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

\*\*\*\*\*

*For Data Collections Purposes Only; Rural Health, Inc. is required to report the following data for all patients. Rural Health, Inc. reports this information **anonymously** and the information you provide will not affect your payment amount.*

**Language spoken (mark all that apply)**

English  Spanish  Other \_\_\_\_\_  Decline to Disclose

**Race**  African American  American Indian  American Indian or Alaska Native  Asian  
 Black  Black or African American  Native Hawaiian  Other Race  White  Decline to Disclose

**Ethnicity**  Central American  Cuban  Dominican  Hispanic or Latino  Mexican  
 Not Hispanic or Latino  Puerto Rican  South American  Spaniard  Declined to Disclose

**Marital Status**  Unknown  Married  Single  Divorced  Separated  Widowed  
 Partner

**Assigned sex at birth**  Male  Female  Choose not to disclose  Unknown

**Pronouns**  he/him  she/her  they/them

**Homebound**  Yes  No

*Homebound if defined as; needing help of another person or medical equipment such as crutches, a walker, or a wheelchair to leave your home, or your doctor believes that your health or illness could get worse if you leave your home.*

**Agricultural Worker**  Yes  No  Patient Declined \*Migrant/Seasonal Status  
 Migrant (*A person/dependent whose principle employment has been in agriculture within The 24 months and has had to establish a temporary home for the purpose of such employment*)  
 Seasonal (*A person/dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment*)

**Homeless Status**  Yes  No  Patient Declined  Doubling up  Homeless Shelter  
 Street  Transitional  Other  Unknown

**Veteran Status**  Yes  No  Patient Declined

**Housing Status**  Public Housing  Not in Public Housing  Patient Declined

**How did you hear about us?**  Advertising  Primary Care Physician  Specialist Physician  
 Word of Mouth  Patient in the Practice  Hospital  Insurance Company  
 Existing Patient  Other please specify if other \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Employer Information**

Patient's Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Occupation: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired  Student  Other

**Emergency Contact**

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Emergency Contact Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Next of Kin**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Guardian**

Last name: \_\_\_\_\_

First name: \_\_\_\_\_ Middle name, suffix \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION** *(Guarantor) Person to be billed, if other than the patient*

RELATIONSHIP TO PATIENT  Self (skip to next section)  Spouse  Parent  Other

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female

Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**MEDICAL \* INSURANCE INFORMATION**

No Insurance  Medicaid/Illinois/MCO  Medicare  Other (Private/Commercial)  Slide Fee Program

❖ **PRIMARY INSURANCE**

Patient's Relationship to Policy Holder:  Self  Spouse  Child  Other

Plan Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holders Date of Birth: \_\_\_\_\_

Effective Date (if known): \_\_\_\_\_ Co-pay Amount \$ \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

❖ **SECONDARY INSURANCE**

None-skip to next section  Medicaid/Illinois/MCO  Medicare  Other (Private/Commercial)

Patient's Relationship to Policy Holder:  Self  Spouse  Child  Other

Plan Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holders Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**DENTAL \* INSURANCE INFORMATION**

No Insurance  Medicaid/Illinois/MCO  Medicare  Other (Private/Commercial)  Slide Fee Program

❖ **PRIMARY INSURANCE**

○ Patient's Relationship to Policy Holder:  Self  Spouse  Child  Other

Plan Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holders Date of Birth: \_\_\_\_\_

Effective Date (if known): \_\_\_\_\_ Co-pay Amount \$ \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

❖ **SECONDARY INSURANCE**

None-skip to next section  Medicaid/Illinois/MCO  Medicare  Other (Private/Commercial)

○ Patient's Relationship to Policy Holder:  Self  Spouse  Child  Other

Plan Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Holder SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holders Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

# INCOME INFORMATION

Income Information – required by federal government to better serve our community

**This is not an application for the Sliding Fee Program**

**State your household income in one of the following categories listed below**

*[ ] Choose not to provide household income*

**2026**

**Please tell us about your family income: Find your family size in the far-left column, Then, go across that same line and circle your Estimated annual household income.**

Family Size	Level A <100% of Poverty level 1-100%	Level B1 <125% of Poverty level 101-125%	Level B2 <150% of Poverty Level 126 to 150%	Level B3 <175% of Poverty Level 151 to 175%	Level B4 <200% of Poverty Level 176 to 200%	Level C >200% of Poverty Level Over 200%
1	\$0 to \$15,960	\$15,960.01 to \$19,950.00	\$19,950.01 to \$23,940.00	\$23,940.01 to \$27,930.00	\$27,930.01 to \$31,920.00	\$31,920.01 and over
2	\$0 to \$21,640	\$21,640.01 to \$27,050.00	\$27,050.01 to \$32,460.00	\$32,460.01 to \$37,870.00	\$37,870.01 to \$43,280.00	\$43,280.01 and over
3	\$0 to \$27,320	\$27,320.01 to \$31,150.00	\$31,150.01 to \$40,980.00	\$40,980.01 to \$47,810.00	\$47,810.01 to \$54,640.00	\$54,640.01 and over
4	\$0 to \$33,000	\$33,000.01 to \$41,250.00	\$41,250.01 to \$49,500.00	\$49,500.01 to \$57,750.00	\$57,750.01 to \$66,000.00	\$66,000.01 and over
5	\$0 to \$38,680	\$38,680.01 to \$48,350.00	\$48,350.01 to \$58,020.00	\$58,020.01 to \$67,690.00	\$67,690.01 to \$77,360.00	\$77,360.01 and over
6	\$0 to \$44,360	\$44,360.01 to \$55,450.00	\$55,450.01 to \$66,540.00	\$66,540.01 to \$77,630.00	\$77,630.01 to \$88,720.00	\$88,720.01 and over
7	\$0 to \$50,040	\$50,040.01 to \$62,550.00	\$62,550.01 to \$75,060.00	\$75,060.01 to \$87,570.00	\$87,570.01 to \$100,080.00	\$100,080.01 and over
8	\$0 to \$55,720	\$55,720.01 to \$69,650.00	\$69,650.01 to \$83,580.00	\$83,580.01 to \$97,510.00	\$97,510.01 to \$111,440.00	\$111,440.01 and over
<b>For a family size greater than 8, for each additional family member, add the following to the upper limit</b>						
9+	\$5,680.00	\$5,680.01 to \$7,100.00	\$7,100.01 - \$8,520.00	\$8,520.01 - \$9,940.00	\$9,940.01 - \$11,360.00	\$11,360.01 and over

**If an income is circled in the Column C range, we thank you for taking the time to complete this form.**

**Please give this form to the receptionist.**

**If an income is circled in the Column A or B1 or B2 or B3 or B4, you may qualify for discounted medical and dental services.**

**PLEASE ASK RECEPTIONIST FOR A SLIDE FEE APPLICATION**

**Internal Use: \*Patient Service Representative: if a patient's income qualifies for A, B1, B2, B3 or B4, please provide patient with a Slide Fee Application APPLICATION PROVIDED TO PATIENT \_\_\_\_\_ OFFICE USE ONLY**  
 Qualify for sliding fee discounts? [ ] YES [ ] NO  
 Patient Declined to Apply \_\_\_\_\_ [ ] <100% [ ] <125% [ ] <150% [ ] <175% [ ] <200%

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ I received the Sliding Fee Application

\_\_\_\_\_ I declined the Sliding Fee Application

\_\_\_\_\_  
**Patient or Guardian Signature (please sign)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**RHI Personnel Signature**

\_\_\_\_\_  
**Date**

**PATIENT FINANCIAL & INSURANCE CONSENT TO TREAT – PRIVACY NOTICE – RELEASE OF MEDICAL INFORMATION PERTAINING TO CLAIMS**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**In consideration of receiving services from Rural Health, Inc, you agree:**

1. All services are provided to you with the understanding that you are responsible for the charges regardless of your insurance coverage. If you would like to know the charge of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
2. At check-in, we will collect your co-pay, deductible, and payment for uncovered services as well as the patient’s portion as determined by insurance or sliding fee scale. We accept cash, check, and credit card of Master Card, Visa, and Discover.
3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **It is the patient’s responsibility to inform our office immediately of insurance coverage or insurance company changes.**
4. You are responsible for knowing if a referral is required. Make sure you know what providers are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.
5. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance company to question why the claim is not paid. Our office will assist you only after you have contacted your insurance company.
6. If your medical claim has not been paid and your insurance company has not resolved your dispute, you may register a complaint with the Illinois Department of Commerce and Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.
7. Any unpaid charges over 90 days old will be sent to an outside collection agency with an additional agency fee. **You are responsible for any collection fees, legal fees, or court costs incurred in the collection process.**
8. Returned checks are subject to a \$25.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the Rural Health Inc., to examine, evaluate, and treat me, and/or my child, or ward. I authorize the RHI to release any/all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the RHI for services rendered. I understand that the RHI will refund any overpayments on my account, in a timely manner.

\_\_\_\_\_**(please initial)** I hereby authorize the release of my medical information necessary to process claims for the services rendered by Rural Health, Inc. and/or the release of medical information necessary for the application of insurance coverage. A copy of this release will be as valid as the original. I further authorize payment of such services rendered to be made directly to Rural Health, Inc. I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_**(please initial)** I have received a copy of the Rural Health, Inc. “Notice of Privacy Practices” and “No Show Policy”.

\_\_\_\_\_**(please initial)** I hereby voluntarily consent treatment, tests, and services I permit Rural Health, Inc. and its employees and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment. I understand that I have the right to withdraw my consent for treatment or tests. I consent to examinations, diagnostic tests, blood tests (including blood tests for any communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), medications, nursing care, and other services or treatment rendered by my provider or other Rural Health, Inc. personnel under the orders or direction of this provider.

Your signature below forms a binding agreement between the RHI (the provider of service) and the Patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of any charges

\_\_\_\_\_**Patient or Guardian Signature (please sign)** \_\_\_\_\_**Date**

\_\_\_\_\_**RHI Personnel Signature** \_\_\_\_\_**Date**



# **RURAL HEALTH, Inc.**

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## **CONSENT FORM FOR MINORS**

I \_\_\_\_\_  
(legal guardian) authorize the following people to  
accompany \_\_\_\_\_  
(minor) for treatment, including but not  
limited to fillings and extractions, and discuss further treatment.

1. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_
2. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_
3. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_
4. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_
5. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

\_\_\_\_\_  
Name (printed) (Photo ID Required)

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Relationship to Patient

**A PHOTO ID IS REQUIRED FOR EACH AUTHORIZED  
PERSON AT THE TIME OF VISIT**



**RURAL HEALTH, Inc.**  
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**RURAL HEALTH, INC. DENTAL CLINIC**  
**Dental Contact Preference Form**

**Phone**

- Home # \_\_\_\_\_  
 Cell # \_\_\_\_\_

**Text Message (text message charges may apply)**

Please list what number we should send text messages to:

\_\_\_\_\_

**Email**

Please list your current email address:

\_\_\_\_\_

Please check **at least** one contact method above.

**Signature:**

\_\_\_\_\_

**Relationship to Patient:**

\_\_\_\_\_

**Date Signed:**

\_\_\_\_\_

THANK YOU.

Dental Contact Form  
03/06/2017 RR



**RURAL HEALTH, Inc.**  
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## Dental/Medical History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Why are you here today? \_\_\_\_\_

Are you having pain or discomfort at this time? \_\_\_\_\_  Yes  No

If yes, what type and where? \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years?  Yes  No

Medical Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Are you taking any medication, drugs, or pills?  Yes  No

If yes, please list: \_\_\_\_\_

Are you taking any prescription blood thinners (Coumadin, Warfarin, Plavix, etc.)?  Yes  No

If yes, please list: \_\_\_\_\_

Are you taking or have you ever taken any prescription weight loss drugs, such as Fen-Phen, etc.?  Yes  No

If yes, please list: \_\_\_\_\_

Are you taking or have you ever taken any prescription medications for an osteoporosis condition (or preventative for this condition) such as the bisphosphonates Fosamax or Boniva, or any others?  Yes  No

If yes, please list: \_\_\_\_\_

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?  Yes  No

If yes, please list: \_\_\_\_\_

Have you ever been diagnosed with or had Lupus or any other autoimmune type diseases?  Yes  No

If yes, please list: \_\_\_\_\_

Do you use two or more pillows to sleep?  Yes  No

Do you use tobacco products (smoke or chew tobacco)?  Yes  No

Do you drink alcoholic beverages?  Yes  No

Are you pregnant?  Does not apply  Yes  No

If yes, when are you due? \_\_\_\_\_

Are you nursing?  Does not apply  Yes  No

Are you taking birth control pills?  Does not apply  Yes  No

**Have you ever had (mark yes or no)?**

Heart Disease or Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Joints (Hip, Knee, Etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dental Phobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arteriosclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cortisone Medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cold Sores/Fever Blisters/Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B (serum)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Thinners	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain in Jaw Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies or Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Surgeries (Please List type and When):</b>								

**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.**

Patient or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**RURAL HEALTH, Inc.**  
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## **RURAL HEALTH, INC. DENTAL CLINIC NO SHOW POLICY**

Dear Patient, Parent, or Guardian of:

Our No Show Policy is strict in order to provide good services to patients. If you have an appointment, you must call to confirm or cancel your appointment within 24 hours (one business day) or your appointment may no longer be reserved for you. Appointment cancellations with less than 24 hours (one business day) notice, are considered to be a missed appointment. Dismissals for continued no shows for new patient appointments will be left to the discretion of the dentist.

For returning patients, the dental clinic will send a letter the first time an appointment is missed without the patient or care giver giving 24 hours notice. For the second missed appointment a warning will be sent. The third missed appointment may result in dismissal from the dental clinic.

Thank you for your cooperation,

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_



**RURAL HEALTH, Inc.**  
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## **No Show Policy**

We are committed to provide quality care at Rural Health, Inc.

An appointment is time allotted for you to meet with a provider for needed services.

**If you are unable to keep your appointment as scheduled, we ask that you please call at least 24 hours in advance and reschedule or cancel.** We realize that emergency situations can arise. If this happens, please call as soon as possible. If you can call ahead and cancel/reschedule your appointment, this can be given to another patient in need of an appointment.

In an effort to provide appointments for all patients that need them and to decrease the number of No Show appointments, Rural Health, Inc. is implementing a No Show Policy. A No Show is defined as a failure to show up for an appointment prior to or within 15 minutes after your scheduled time without calling to cancel or reschedule prior to the appointment time.

**No Shows will be documented in your medical record. If you miss three (3) appointments in a row or three (3) appointments in a six (6) month period without calling before the appointment to cancel/reschedule, you may be discharged from Rural Health, Inc. services.**



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## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Starting April 13, 2003, Rural Health, Inc. (RHI) is required to maintain the privacy of your protected health information as a result of the Health Insurance Portability and Accountability Act (HIPAA). Your “protected health information” means health information, including demographic information (for example, your name, address, and phone number) collected from you and created or received by the physician, another health care provider, a health plan, or a health care clearinghouse.

RHI must follow this Notice until it is replaced. This notice explains how RHI can use or share your health information. It also explains your rights. RHI reserves the right to change the terms of this Notice at any time. If RHI changes this Notice, a copy of the current Notice will be posted in a prominent location. We will provide you with any revised notice of Privacy Practices when you ask. To get a copy of RHI’s Notice of Privacy Practices, you may access our website at [www.ruralhealthinc.org](http://www.ruralhealthinc.org), call any office and request a revised copy be sent to you in the mail, or you may ask for one at the time of your next appointment.

### Purposes for which RHI may use or disclose your personal health information without your authorization:

- Health Care Treatment Purposes. For example, RHI may disclose our personal health information to your doctor, at the doctor’s request, for treatment by your doctor.
- Payment. For example, RHI may use or disclose your personal health information to provide eligibility information to your doctor when you receive treatment, to pay for claims for covered health care services, or to recover costs from other medical insurance.
- Health Care Operations. For example, RHI or its contractors may use or disclose your personal health information (1) to conduct quality assessment and improvement activities; (2) to review applications for services; (3) to engage in care coordination or case management; (4) to manage, plan or develop RHI’s services and budget; (5) to coordinate services with another public benefit program; or (6) to cooperate with state and federal auditors.
- Health Services. RHI or its contractors may contact you, for example to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- As Required by Law. For example, RHI is required by law to allow the United States Department of Health and Human Services to audit RHI records. RHI may disclose your personal health information necessary to comply with workers’ compensation or other laws. RHI may also be required to disclose personal health information about abuse, neglect, or domestic violence to governmental or social services agencies.
- For other Reasons:
  - To comply with legal proceedings, such as a court or administrative order or subpoena.
  - To law enforcement officials or to correctional institutions for limited law enforcement and health and safety purposes.
  - With your written authorization, to a family member, friend or other person, to help you with your health care or payment for your health care.
  - To your personal representative appointed by you or designated by law.
  - For research purposes in limited circumstances and where the information will be protected by the researchers
  - To a coroner, medical examiner, or funeral director to identify a deceased person or to arrange payment benefits.
  - To an organ procurement organization, in limited circumstances.
  - To avert a serious threat to your health or safety or health or safety of others.
  - To a governmental agency authorized to oversee government health care programs.
  - To federal officials for lawful national security purposes.
  - To public health authorities for public health purposes.

- To appropriate military authorities, if you are a member of the armed forces.

Uses and disclosures with your permission. RHI will not use or disclose your personal health information for any other purposes unless you give RHI your written authorization to do so. In most cases, you may revoke your written authorization at any time, unless RHI has relied upon your authorization for a continuing disclosure, for example, for a research study. Your revocation will be effective from the date RHI receives the revocation forward, for all your personal health information that RHI maintains. Authorization and Revocation forms are available at all RHI offices.

Your Rights. You may make a written request to RHI to do one or more of the following concerning your personal health information that RHI maintains:

- To put additional restrictions on RHI's use and disclosure of your personal health information. RHI does not have to agree with your request.
- To have RHI communicate with you in confidence about your personal health information by a different means or at a different location than RHIS is currently doing. Your request must be in writing specifying the alternative means or location to communicate with you.
- To see and get copies of your personal health information, except for psychotherapy notes or information for use in a civil, criminal or administrative action or proceeding (this is a federal law). You may be charged a fee for copies.
- To correct your personal health information. In some cases, RHI does not have to agree to your request.
- To receive a list of disclosures of your personal health information that RHI and its contractors made for certain purposes for the last six years, but not for disclosures made before April 14, 2003.

If you want to exercise any of these rights described in this Notice, please contact the RHI Privacy Officer at the address below. RHI will give you the necessary information and forms for you to complete and return to RHI.

Complaints. If you believe your privacy rights have been violated by RHI, you have the right to complain to RHI or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with RHI at the address where you receive services. RHI will not retaliate against you if you choose to file a complaint with RHI or with the U.S. Department of Health and Human Services.

Privacy Officer. To request additional copies of this Notice or to receive more information about RHI's privacy practices, your rights or to file a complaint, please contact the Privacy Officer at the following address:

RHI Privacy Office  
Rural Health, Inc.  
513 North Main Street  
Anna, Illinois 62906  
Phone 618-833-4471



# **RURAL HEALTH, Inc.**

*We specialize in you*

*We value your input and want to hear about your experience as a Rural Health, Inc. patient.*

*This is your opportunity to tell us what we did well and where we need improvements.*

*Please provide us your **email** and you will receive a patient satisfaction survey following your visit with us.*

*Thank you for helping us grow.....*





**RURAL HEALTH, Inc.**  
*We specialize in you*

*Anna Main / Dongola / Goreville / Metropolis / Vienna*

**Even when we are not here.....we have you covered**

Did you know you can reach a medical provider 24/7 by simply calling the office? Your call will be connected to an answering service who will contact the Rural Health, Inc. medical provider if indicated.

**If you are experiencing a medical emergency, call 911 or go to your nearest emergency room.**

**Cuando no estamos aquí ..... lo podemos cubrir.**

¿Sabía usted que usted puede alcanzar a un doctor médico 24/7 por simplemente llamando la oficina? Su llamada estará relacionada con un servicio de contestación automática quién se pondrá en contacto con el Rural Health, Inc doctor médico como indicado.

**Si usted tiene una urgencia médica, llame 911 o vaya a su cuarto de emergencia más cercano.**

***\*\*\*The after-hours answering service for Rural Health, Inc. offers over 350 languages to serve you better.***